CONNECT for HEALTH COLORADO™

EN-002-02

Individual Connect for Health Colorado Addendum

Instructions: If you are submitting this application through Connect for Health Colorado, please fill out and submit this addendum as well. If you have more people to include, make a copy of pages 3-5 and attach. **The person who is signing this application and addendum must fill out the entire addendum.**

Privacy Statement

Connect for Health Colorado (the Marketplace) will maintain information you provide as private as required by law. The information you provide will be used for purposes of treatment; payment; determining eligibility; or other purposes permitted by law.

As part of the process, we will communicate with you or your authorized representative, and then provide the information to the health plan you select so that they can enroll those who are eligible in a qualified health plan. Information on race and ethnicity will not be provided to the insurance carriers, unless you are an American Indian or Alaska Native because that information could positively affect your benefits. We will verify your answers using information in our electronic databases and the databases of partner agencies. If the information you provide does not match these sources, we may ask you to send us proof of the information you provide.

Health insurance carriers can no longer deny coverage based on your health status. Household members who do not want insurance will not be asked questions about citizenship or immigration status.

If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health insurance for three months or longer during the year, you may be subject to a federal penalty.

Important: Connect for Health Colorado is authorized to collect information on the application, including Social Security numbers, and will confirm information that may affect initial or ongoing eligibility for all persons listed on your application. You are allowing Connect for Health Colorado to use Social Security numbers and other information from your application to request and receive information or records to confirm the information in your application. You release Connect for Health Colorado from all liability for sharing this information with other agencies for this purpose. For example, Connect for Health Colorado may get and share your information with any of the following agencies: Social Security Administration; United States Customs and Immigration Services; Department of Homeland Security; Centers for Medicare and Medicaid Services; other federal or state agencies; and Agents/Brokers and managing general agencies contracting with those agents/brokers, as applicable, which are certified by the Marketplace to assist applicants/enrollees. We need this information to check your eligibility for health insurance and to give you the best service possible if you choose to apply.

Regulations that support getting this data can be found under the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), the Social Security Act, and Colorado S.B. 11-200, the Colorado Health Benefit Exchange Act, codified at C.R.S. § 10-22-101.

Privacy Statement

We may use the information you provide in computer matching programs with any of the following entities to make eligibility determinations, to verify continued eligibility for enrollment in a qualified health plan, or to process appeals of eligibility determinations:

- Other verification sources including consumer reporting agencies;
- Applicants/enrollees, and authorized representatives of applicants/enrollees;
- Issuers of qualified health plans, as applicable, which are certified by Colorado Division of Insurance;
- Agents and brokers, as designated or nominated by the applicant/enrollee, who are certified by the Marketplace to assist applicants/enrollees;
- Financial institutions (banks, credit unions, etc.) including Network Merchants, Inc. for all ACH/ credit card payments;
- Connect for Health Colorado contractors engaged to perform a function for the Marketplace; and
- Anyone else as required by law.

The Marketplace will also use the information you provide as part of the ongoing operation of this organization, including activities such as performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information. We use your personally identifiable information for our internal business purposes only, and we do not sell or trade it.

As part of overall performance and effectiveness monitoring, the Marketplace utilizes Google Analytics to identify and track customer activities to analyze communication campaigns, website navigation, and potential bottlenecks.

For additional information about Google Analytics, please see HYPERLINK "http://www.google.com/policies/privacy/partners/" How Google uses data when you use our partners' sites or apps

Protection of your data: Connect for Health Colorado has significant protections in place to ensure the privacy of your personal information. The Marketplace system is being implemented in compliance with federal and state rules, regulations, and laws designed to protect customer information.

☐ **By checking this box**, I agree to allow my information to be used and collected from data sources for this application. I have consent for all people I list on the application allowing collection of information about them from data sources for this application.

1. Who does this addendum apply to:

Name (First)	(Middle)	(Last)	Suffix

Individual Shared Responsibility Exemption

2. Does this person have an individual shared responsibility exemption*? ☐ **Yes** ☐ **No**

If Yes, Exemption Certificate Number: _____

Ethnicity & Race (optional)

3. Is this person of Hispanic, Latino, or Spanish origin? ☐ **Yes** ☐ **No**

Ethnicity: (check all that apply)

☐ Cuban
☐ Mexican, Mexican American, or Chicano/a
☐ Puerto Rican
☐ Other: _____

Race: (check all that apply)

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White or Caucasian
☐ Other: _____

American Indian/Alaska Native

4. Is this person a member of a Federally-recognized Tribe? ☐ **Yes** ☐ **No**

If Yes, complete the information below:

_____

Tribe name and State

Non-Citizens

5. Is this person a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**

6. Is this person a naturalized citizen? ☐ **Yes** ☐ **No**

Document Type (select one.)

☐ Naturalization certificate:
Alien Number_____ Naturalization Number_____ ☐ I don't have one.

☐ Certificate of citizenship:
Alien Number_____ Citizenship Certificate Number_____ ☐ I don't have one.

Non-Citizens (Continued)

☐ Check if this person has eligible for immigration status:

Document Type (select one)

☐ Reentry Permit (I-327)

☐ Permanent Resident Card ("Green Card," I-551)

☐ Refugee Travel Document (I-571)

☐ Employment Authorization Card (I-766)

☐ Machine Readable Immigrant Visa (with temporary I-551 language)

☐ Temporary I-551 Stamp (on passport or I-94, I-94A)

☐ Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services

☐ Arrival/Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection

☐ Arrival/Departure Record in unexpired foreign passport (I-94)

☐ Unexpired foreign passport

☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)

☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

☐ Other documents or status types:
Alien Number: _____
I-94 Number: _____
Passport or Document Number: _____
Foreign Passport Country of Issuance: _____
Passport Expiration Date: _____
SEVIS ID Number: _____
Document Description: _____

Other Documentation:

☐ Document indicating American Indian born in Canada (LPR – I-551)

☐ Document indicating member of a Federally-recognized Tribe (If selected, you will be required to upload supporting documentation)

☐ Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)

☐ Office of Refugee Resettlement (ORR) eligibility letter (if under 18)

☐ Cuban/Haitian Entrant Document indicating withholding of removal Resident of American Samoa (If selected, you will be required to upload supporting documentation)

☐ Resident of Commonwealth of the Northern Mariana Islands (If selected, you will be required to upload supporting documentation)

☐ Other:
Alien Number: _____
I-94 Number: _____
Comments: _____

Non-Citizens (Continued)

7. Is this person's name the same name that appears on his/her document?

8. If this person's name is different on his/her document, enter the same name as shown on the document:

Name (First)	(Middle)	(Last)	(Suffix)

9. Has this person lived in the U.S. since 1996? ☐ **Yes** ☐ **No**

10. Is this person, their spouse, or their parent an honorably discharged veteran or active duty member of the military? ☐ **Yes** ☐ **No**

No Social Security Number

11. If this person is applying for coverage, does this applicant NOT have a Social Security Number?

Why? ☐ Has applied for SSN ☐ Illness ☐ Religion ☐ Legally Present Non-Citizen

Other Address

12. Does this person live at the same physical address as the Primary Applicant or are you the Primary Applicant?

☐ **Yes** ☐ **No** **If No**, complete the information below:

13. Legal Name of Spouse (First)	(Middle)	(Last)	(Suffix)

14. Address	15. Apartment #/Suite

16. City	17. State	18. ZIP code

19. Is this person living outside Colorado temporarily? ☐ **Yes** ☐ **No**

If Yes, who?_____

If Yes, where will he/she be living in Colorado in he/she returns?

City	Zip	County

Assistance with Completing this Application and Addendum

You can choose an authorized representative.
This trusted person would be given permission to talk about this application and addendum with Connect for Health Colorado, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative" and takes legal responsibility for the information provided in this application. If you ever need to change your authorized representative, contact Connect for Health Colorado.

20. Name of authorized representative (First) (Middle) (Last) (Suffix)

21. Address

22. Apartment or suite number

23. City

24. State

25. ZIP code

26. Phone number

Ext.

Phone Type: ☐ Cell ☐ Home ☐ Work

27. Email address

28. Company/Organization name (if applicable)

29. Company/Organization ID number (if applicable)

By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.

Applicant's Signature

Date (mm/dd/yyyy)

☐ I, the **authorized representative**, would like to submit proof of a legal reason that the Primary Contact cannot represent themselves. (Please provide a copy of one of the following documents with this application when it is submitted: a power of attorney, court order establishing legal guardianship, or other legal document explicitly stating that you may legally act on behalf of the customer.)

For certified application counselors, health coverage guides, agents, and brokers only.

Complete this section if you are a certified application counselor, health coverage guide, agent, or broker filling out this application.

30. Application Start date (mm/dd/yyyy):_____

31. Select one: ☐ Counselor ☐ Health coverage guide ☐ Agent/broker

32. Name (First) (Middle) (Last) (Suffix)

33. ID Number (Guide ID or state license number, as applicable)

Rights, Responsibilities and Penalties

1. I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,_____ is incarcerated.
(Name of Person)
Is this person(s) pending disposition? ☐ **Yes** ☐ **No**

2. I understand that my answers, together with any supplements or additional pages, are the basis for policy that is issued.

3. I agree that no insurance will be effective until the date specified by the insurance company providing the certificate, policy, or notice.

4. I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible copy signature shall have the same force and effectiveness as the original.

5. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued. I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate if it is determined that I or family member made an intentional misrepresentation in the application.

6. I know I have 30 calendar days to report any changes to the information I listed on this application to Connect for Health Colorado if I am enrolled in a Qualified Health Plan. I understand that a change in my information could affect my eligibility.

7. Following federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file

8. I have agreed to submit this application for myself and/or my family. By signing this application/addendum, I certify that I have reviewed this application; that I understand and agree to the statements in the Rights, Responsibilities and Penalties section; and that under penalty of perjury, I certify the information I have given is true. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty. Penalties may include imprisonment, fines, denial of insurance and civil damages.

9. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

My right to appeal: If I think Connect for Health Colorado has made a mistake, I can appeal its decision. To appeal means to tell someone at Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-855-PLANS-4-YOU or by visiting our website at ConnectforHealthCO.com. My eligibility and other important information will be explained to me.

Sign this addendum. The primary policy holder should sign this addendum. If you are an authorized representative, you may sign here as long as you have provided the required information in the Assistance with Completing this Application and Addendum section.

Signature _____ Date (mm/dd/yyyy) _____

NEED HELP WITH YOUR APPLICATION? See our contact information on page 8 of this addendum.

Mail completed application and addendum

Connect for Health Colorado
Individual Applications
P.O. Box 35033
Colorado Springs, CO 80935

ConnectforHealthCO.com
1-855-PLANS-4-YOU (1-855-752-6749)

Note: If you need help in a language other than English, call and tell the customer service representative the language you need.

En Español: Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español, al 1-855-PLANS-4-YOU (1-855-752-6749).

TTY/TDD: 1-855-346-3432

* Individual shared responsibility exemption: You may be exempt from the federal requirement to have health insurance if any of the following apply: you are a legal resident of the United States with very low income but you do not qualify for Medicaid; you are part of a religion opposed to acceptance of benefits from a health insurance policy; you are a member of an American Indian or Alaska Native Tribe who is eligible to receive services through an Indian health care provider (such as the Indian Health Service (IHS), a Tribal health program, or urban Indian health programs); or you qualify for a hardship exemption due to very low income. If you qualify for an exemption, you can either opt-out of having health insurance (and do not need to fill out this application) or purchase a high-deductible plan through the Marketplace once you have the exemption. To find out how to apply for the exemption, contact one of the following: the Federal government at healthcare.gov, 1-800-318-2596, or TTY at 1-855-889-4325 OR you may contact Connect for Health Colorado by starting an online chat at ConnectforHealthCO.com using the 'Get Assistance' button or by calling 1-855-PLANS-4-YOU (1-855-752-6749).